

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/12/2016
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on November 23, 2015.</p> <p>Survey dates: January 12, 2016</p> <p>Facility number: 012940 Provider number: 012940 AIM number: N/A</p> <p>Residential census: 46</p> <p>Sample: 3</p> <p>Bickford of Crown Point was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Survey.</p> <p>Quality review completed by 26143, on January 12, 2015.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE